

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08956100

<b>1. PLACE OF DEATH:</b> County <u>Stearns</u> City or town <u>La Plata, Md</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>3 days</u> Hospital, institution, or street address where death occurred: <u>Physicians Memorial Hospital</u> How long in hospital or institution? <u>x</u>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>St Marys</u> City or town <u>Mechanicville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____		
<b>3. (a) FULL NAME</b> <u>Janie Anderson</u>			<b>3. (b) Social Security Number</b> <u>none</u>		
<b>4. Sex</b> <u>Female</u>			<b>5. Color or race</b> <u>white</u>		
<b>6. (a) Single, married, widowed, or divorced</b> <u>married</u>			<b>6. (b) Name of husband or wife</b> <u>Thomas T. Anderson</u>		
<b>6. (c) If alive, give age</b> <u>64</u> years			<b>7. Birth date of deceased (mo., day, yr.)</b> <u>Sept 2, 1892</u>		
<b>8. AGE:</b> Years <u>54</u> Months <u>-</u> Days <u>7</u> (It less than one day) _____ hrs. _____ min.			<b>9. Birthplace</b> <u>Charles Co</u> (Town, county, and state)		
<b>10. Usual occupation</b> <u>House wife</u>			<b>11. Industry or business</b> <u>None</u>		
<b>12. Name</b> <u>Joseph Murphy</u>			<b>13. Birthplace</b> <u>Charles Co, Md</u>		
<b>14. Maiden name</b> <u>Maggie Probe</u>			<b>15. Birthplace</b> <u>St Marys Md</u>		
<b>16. Informant</b> <u>Thomas T. Anderson</u> Address <u>Mechanicville</u>			<b>17. Burial</b> (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>Sept 12 1946</u> (month) (day) (year) Cemetery or crematory <u>St Josephs Cemetery</u> Location <u>Marysville, Md</u>		
<b>18. Funeral director</b> <u>Shirley E. Price</u> Address <u>Hughesville, Md</u>			<b>19. (Date rec'd by registrar)</b> <u>9-10-46</u>		
<b>20. DATE OF DEATH</b> <u>Sept 9, 1946</u> at <u>8:30</u> P.M.			<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Sept 7, 1946</u> to <u>Sept 9, 1946</u> and that I last saw him alive on <u>Sept 9, 1946</u>		
<b>Immediate cause of death</b> <u>Pulmonary Edema</u>			<b>DURATION</b> <u>12 hours</u>		
<b>Due to</b> <u>myocardial failure</u>			<u>12 hours</u>		
<b>Due to</b> <u>Hypertensive Cardiac</u>			<u>10 years</u>		
<b>Other conditions</b> <u>Obesity</u>			(Include pregnancy within 3 months of death)		
<b>Major findings of operations</b> _____ Date of op. _____					
<b>Autopsy results</b> <b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>					
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where)? _____ Means of injury _____ Injured at work? _____					
<b>23. SIGNATURE</b> <u>Louis C. Garcia, M.D.</u> Address <u>Hughesville, Md</u> Date signed <u>9-9-46</u>					

Bureau - 100th 9/12/46



M

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

75d

## CERTIFICATE OF DEATH

Reg. Dist. No. 0635725

## 1. PLACE OF DEATH

County CharlesCity or town La Plata Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ellie M Bowdish

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed or divorced

Wid

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Aug 19-1881

8. AGE:

Years

Months

Days

If less than one day

65

hrs. min.

9. Birthplace

Canada

(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

12. Name

George Richter

13. Birthplace

Baltimore Md

MOTHER

14. Maiden name

Catherine M Stool

15. Birthplace

Piney Stool Md

16. Informant

Mrs Hadro Zvonchens

Address

Brandywine Md

17.

Burial

Date thereof

9-19-46

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Episcopal

Location

Chatterham Md

18. Funeral director

Hunt & Ryson

Address

Brady Md

19.

Sept 18 1946

19.

M R Montoy

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Charles

City or town

Wally

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

Bowdish

## MEDICAL CERTIFICATION

20. DATE OF DEATH

9-161946, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-161946, to 9-16 1946and that I last saw h.e.R. alive on9-161946

Immediate cause of death

Coronary Thrombosis

DURATION

9-16-46

Due to

Due to

Enteric Severe Heart Disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Edell

M. D. or other

Address

La Plata Md

Date signed

9-17-46

RECEIVED

SEP 24 1945

BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

## CERTIFICATE OF DEATH

08958

Reg. Dist. No. 101

### 1. PLACE OF DEATH:

County.....Charles  
City or town.....Beltsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....16 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....Maryland County.....Charles  
City or town.....Beltsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Clifford Norris Bowie

### 3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Married  
6.(b) Name of husband or wife.....Eula V. Bowie  
B.(c) If alive, give age.....42 years  
7. Birth date of deceased (mo., day, yr.).....October 3 1885  
8. AGE: Years.....60 Months.....11 Days.....20 If less than one day..... hrs. .... min.

9. Birthplace.....Cross Roads, Chase Co. (Town, county, and state)  
10. Usual occupation.....Carpenter  
11. Industry or business.....  
12. Name.....Thomas E. Bowie  
13. Birthplace.....Nantuxony, Md.  
14. Maiden name.....Mary E. Posey  
15. Birthplace.....Cross Roads, Md.

16. Informant.....Mr. Elora Wright  
Address.....Unsubscribed, Md.  
17.....Burial Date thereof.....Sept 15 1946  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory.....Baptist  
Location.....Nantuxony Md.  
18. Funeral director.....Waldorf & Son  
Address.....Waldorf Md.

19.....Sept 14.....1946.....Mary Smithland  
(Date rec'd by registrar) (year) (month) (day) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....Sept 13 1946 at 12:30 M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....born.....Sept 13 1946  
and that I last saw him/her alive on.....Sept 13 1946

Immediate cause of death.....Carcinoma (Gastric)  
Due to.....Operation  
Due to.....George Washington  
Other conditions.....Hospital  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury..... Injured at work?

23. SIGNATURE.....Wm. C. Bicknell  
Address.....Marbury Md. Date signed.....Sept 14 1946  
M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REPORT TO THE SECRETARY OF THE ARMY

ON THE PROGRESS OF THE WORK

OF THE ARMY ENGINEERING SCHOOL

FOR THE YEAR 1918

REPORT OF THE

COMMISSIONER

OF THE ARMY ENGINEERING SCHOOL

RECEIVED  
SEP 25 1918  
BUREAU V.B.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-2

## CERTIFICATE OF DEATH

08959  
★ Reg. Dist. No. 106

1. PLACE OF DEATH:  
County.....*Charles*  
City or town.....*Potomac Heights*  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....*Maryland* County.....*Charles*  
City or town.....*Indian Head*  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME.....*Gustavus A. Brown*  
3. (b) Social Security Number.....

4. Sex.....*Male* 5. Color or race.....*White* 6.(a) Single, married, widowed, or divorced.....*Married*  
8.(b) Name of husband or wife.....*Rouise Brown* 6.(c) If alive, give age.....*55* years  
7. Birth date of deceased (mo., day, yr.).....*Feb. 14 1865*

8. AGE: Years.....*81* Months.....*5* Days.....*18* If less than one day.....*hrs min.*

9. Birthplace.....*Falls Church Virginia*  
(Town, county, and state)

10. Usual occupation.....*Power factory attendant*

11. Industry or business.....*Retired*

12. Name.....*Jalm A. Brown*

13. Birthplace.....*Florida*

14. Maiden name.....*Marietta Busley*

15. Birthplace.....*New York*

16. Informant.....*Frances Brown*

Address.....*Baltimore Md*

17. *Sep 3 Burial* Date thereof.....*Sep 3 46*  
(Burial, cremation, or removal, Which)..... (month) (day) (year)

Cemetery or crematory.....*Shiloh*

Location.....*Bryons Road*

18. Funeral director.....*Hunt & Ryan*

Address.....*Waldorf, Md.*

19. *9/3* *46* *Grey Price*  
(Date rec'd by registrar)..... Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Sep. 1* 19.....*46* at.....*130* A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*Jan.* 19.....*46* to.....*Sep. 1* 19.....*46*  
and that I last saw him.....*Aug 31* 19.....*46*  
alive on.....

Immediate cause of death.....*Cardio-renal disease*  
Due to.....*arteriosclerosis*

Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
.....Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (Country) (State)  
Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?

23. SIGNATURE.....*Geo. O. Bicknell MD*  
Address.....*Marbury, Md* M. D. or other.....  
Date signed.....*Sep 1 46*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

SEP 5 1946

BUREAU OF



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-8)

## CERTIFICATE OF DEATH

08860

Reg. Dist. No. 100

### 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

### 3. (a) FULL NAME

*Agnes Bertha Epp*

### 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

*Female white Single*

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) *Feb 18 1930*

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. *Burial* Date thereof.....  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. *9-21* 19 *46* *Julius H. Posey*  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... 19 *46* at *8 P* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *5-4* 19 *46* to *9-20* 19 *46*

and that I last saw him/her alive on *9-2* 19 *46*

Immediate cause of death.....  
*Cancer of Bone (Hip)*

### DURATION

*5-4-46*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... 19 *46*  
M. D. or other

Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 24 1945  
BUREAU V. M.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

## CERTIFICATE OF DEATH

Reg. Dist. No. 105

## 1. PLACE OF DEATH:

County..... Charles  
 City or town..... Benedict  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Several days  
 Hospital, institution, or street address where death occurred..... Patuxent River  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Va. County..... Fairfax  
 City or town..... Annadale (Burke Co.)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Amos Franklin Fillingame

## 3. (b) Social Security Number

4. Sex..... male  
 5. Color or race..... white  
 6. (a) Single, married, widowed, or divorced..... Married  
 6. (b) Name of husband or wife..... ~~Harold~~ Wilma Taylor Fillingame  
 6. (c) If alive, give age..... 18 years  
 7. Birth date of deceased (mo., day, yr.)..... March 17, 1924  
 8. AGE: Years..... 22 Months..... 6 Days..... 1 It less than one day..... hrs. min.

9. Birthplace..... Fairfax Co., Va.  
 (Town, county, and state)  
 10. Usual occupation..... Shoemaker  
 11. Industry or business.....

12. Name..... Harry Fillingame  
 13. Birthplace..... Loudoun Co., Va.  
 14. Maiden name..... Sallie Glascock  
 15. Birthplace..... Fauquier Co., Va.  
 16. Informant..... Harry Fillingame  
 Address..... Fairfax Co., Va.  
 17. Removal..... Date thereof..... Sept 21-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....  
 Location..... Vienna Va  
 18. Funeral director..... Money & King  
 Address..... Vienna Va  
 19. Sept 21 1946 M.R. Moore  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 21, 1946 at 5:00 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ on Sept 21, 1946, to Sept 21, 1946, and that I saw him ~~alive~~ on Sept 21, 1946.  
 Immediate cause of death.....

Accidental drowning  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of..... 9-15-46  
 Where did injury occur?..... Benedict, Charles, Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)..... Patuxent River  
 Means of injury Drowned while swimming Injured at work? No  
 23. SIGNATURE..... J. MacKinnon, M.D.  
 Address..... S. Photo, Md. Date signed..... 9-21-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 24 1944  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Make correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-2)

## CERTIFICATE OF DEATH

08962

Reg. Dist. No. 100

## 1. PLACE OF DEATH:

County... Charles  
 City or town... Newport  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 months  
 Hospital, institution, or street address where death occurred:  
St. Mary's Church grounds  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Calvert  
 City or town... Solomons Island  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Claire A. Fowler

## 3. (b) Social Security Number

4. Sex female 5. Color of race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife James M. Fowler 6. (c) If alive, give age 51 years  
 7. Birth date of deceased (mo., day, yr.) Feb. 14, 1895  
 8. AGE: Years 51 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Calvert County, Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business none

MOTHER FATHER  
 12. Name George Stinneth  
 13. Birthplace Calvert County  
 14. Maiden name Mandy Stinneth  
 15. Birthplace Calvert County  
 16. Informant Husband  
 Address Newport, Md.  
 17. Burial Date thereof 9-20-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Home  
 Location Dr. Frederick Calvert Co. Md.  
Wm. H. Gulebski  
 19. Funeral director Amens, Md.  
 Address 9-19-46  
 (Date rec'd by registrar) 19 Julia H. Pacey  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 19 46 at 4 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15th 19 46 to Sept 18 19 46  
 and that I last saw him alive on Sept 18th 19 46

Immediate cause of death Bronchogenic Carcinoma DURATION 3 months

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Louis B. Garcia M.D.  
 Address Hagerstown, Md. M. D. or other \_\_\_\_\_  
 Date signed Sept 19, 1946

RECEIVED

SEP 20 1946

BUREAU VS



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 08963, 05

<b>1. PLACE OF DEATH</b> County <u>Charles</u> City or town <u>Waldorf md</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Life</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>md</u> County <u>Charles</u> City or town <u>Waldorf md</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Tam E. Garner</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>7</u>		<b>5. Color or race</b> <u>W</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>married</u>		<b>MEDICAL CERTIFICATION</b>	
<b>6. (b) Name of husband or wife</b> <u>Edward</u>				<b>20. DATE OF DEATH</b> <u>9/19</u> 19 <u>46</u> at <u>4:50</u> P.M.			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>July 25 - 1875</u>				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Jan 38</u> 19 <u>19</u> to <u>9/19</u> 19 <u>46</u> and that I last saw him alive on <u>9/19</u> 19 <u>46</u>			
<b>8. AGE:</b> Years <u>71</u> Months Days If less than one day hrs. min.				<b>Immediate cause of death</b> <u>Caudice</u> <u>Decompensation</u> Due to <u>Caudice - Uter -</u> <u>Renal Disease</u> Due to Other conditions <u>Diabetes Mellitus</u> (Include pregnancy within 3 months of death)			
<b>9. Birthplace</b> <u>Waldorf md</u> (Town, county, and state)				<b>DURATION</b> <u>46</u>			
<b>10. Usual occupation</b> <u>Housewife</u>				<b>Major findings of operations</b> Date of op.			
<b>11. Industry or business</b>				<b>Autopsy results</b> <b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>12. Name</b> <u>Bessie Williams</u>				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>			
<b>13. Birthplace</b> <u>Waldorf md</u>				Accident, suicide, or homicide Date of			
<b>14. Maiden name</b> <u>Elizabeth Pickens</u>				Where did injury occur? (City or town) (County) (State)			
<b>15. Birthplace</b> <u>Waldorf</u>				Injured at home, farm, industry, public place (where?)			
<b>16. Informant</b> <u>Elise Garner</u>				Means of injury Injured at work?			
Address <u>Waldorf md</u>				<b>23. SIGNATURE</b> <u>Dr. P. W. W. M.D.</u> M.D. or other			
<b>17. Burial, cremation, or removal, Which?</b> <u>Burial</u> Date thereof <u>9-22-46</u> (month) (day) (year)				Address <u>Waldorf, Md.</u> Date signed <u>9/19/46</u>			
Cemetery or crematory <u>Oakland</u>							
Location <u>Waldorf md</u>							
<b>18. Funeral director</b> <u>Smith &amp; Ryan</u>							
Address <u>Waldorf md</u>							
<b>19. Date rec'd by registrar</b> <u>Sept 21 46</u> Registrar <u>M. P. Mowrer</u>							

VS A15 9.45.15

(I)

MARGIN RESERVED FOR BIN

PLEASE WRITE PLAINLY, WITH UNFADING INK

Supply every item

RECEIVED  
SEP 23 1946  
BUREAU V

M

Information can only be obtained by the competent authority

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

## CERTIFICATE OF DEATH

Reg. Dist. No. 08964 105

### 1. PLACE OF DEATH:

County Charles  
City or town near Pomonoke md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Prince Georges  
City or town Rumacoke md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Hence C Giles Jr  
M W M  
5. Color or race 6. (a) Single, married, widowed, or divorced

### 3. (b) Social Security Number

### 6. (b) Name of husband or wife

Elizabeth  
7. Birth date of deceased (mo., day, yr.) 1893  
6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
53 hrs. min.

9. Birthplace Frontsview va  
(Town, county, and state)

10. Usual occupation carpenter

1. Industry or business

12. Name Hence C Giles Sr

13. Birthplace Blue Ridge va

14. Maiden name Bertha Swelmer

15. Birthplace va

16. Informant Elizabeth Giles

Address accoke md

17. Burial Date thereof 9-14-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory arlington nat

Location arlington va

18. Funeral director Hunt & Ryan

Address Waldorf md

19. Sept 13 46 on R. Smoore

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11 19 46 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Coroner's Case  
and that I last saw h. alive on 19 46

Immediate cause of death Cerebral Hemorrhage  
Due to Bullet Wound  
Due to suicide 9-11-46  
Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide suicide Date of 9-11-46  
Where did injury occur? Chas md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Bullet Injured at work?

23. SIGNATURE R. Edgewood M.D.  
Address Laurel Md Date signed 9-11-46  
M.D. or other

death clearly and legibly.

please write the ca

is especially important. Physician

RECEIVED  
OCT 4 1946  
BUREAU V B

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

## CERTIFICATE OF DEATH

18965

Reg. Dist. No. 100

### 1. PLACE OF DEATH:

County..... Charles  
City or town..... Newburg  
(If outside city or town limits, give RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
—  
How long in hospital or institution? —

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md. County..... Charles  
City or town..... Newburg  
(If outside city or town limits, give RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) if veteran, name war.....

### 3. (a) FULL NAME

Marion B Hungerford

### 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

Female white married

6.(b) Name of husband ~~late~~ A. H. Hungerford

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) August 4, 1904

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.  
42 1 10 .....

9. Birthplace..... Newburg, Charles, Ind.  
(town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... Own home

12. Name..... William Laird Blunt

13. Birthplace..... Washington, D. C.

14. Maiden name..... Edith B. Matthews

15. Birthplace..... Charles Co., Ind.

16. Informant..... Harry W. Blunt

Address..... 7901 - Rodman Rd., Bethesda, Md.

17. Burial Date thereof..... 9-16-46  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory..... Christ Church

Location..... Capitol Hill

18. Funeral director..... Hunt & Ryan

Address..... Waldorf, Ind.

19. 9-16-46 19..... Julia H. Pacey  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept. 14, 19 46, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2, 19 46, to Sept. 14, 19 46, and that I last saw him alive on Sept. 13, 19 46.

Immediate cause of death.....

Acute myeloid leukemia 7 months

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... James L. MacKavanagh, M.D. M. D. or other

Address..... La Plata, Md. Date signed 9-14-46

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 17 1946  
BUREAU V K



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (312)

## CERTIFICATE OF DEATH

 08966  
 Reg. Diat. No. 105-

## 1. PLACE OF DEATH:

County Charles  
 City or town White Plains md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 mo  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Chas  
 City or town Wadsworth md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Benjamin F. King

## 3. (b) Social Security Number

4. Sex MA 5. Color or race M 6. (a) Single, married, widowed, or divorced Single

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1875 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 71 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace 2 B Prince Geo Co md  
 (Town, county, and state)  
Tubors

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER 12. Name John R. King  
 13. Birthplace 2 B md

MOTHER 14. Maiden name Melania King  
 15. Birthplace 2 B md

16. Informant William King  
 Address Wadsworth md

17. Burial Date thereof 9-10-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakland  
 Location Wadsworth md  
Smith & Ryan

18. Funeral director Smith & Ryan  
 Address Wadsworth md

19. Sept 9 46 Registrar Wadsworth

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1946 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/20 1946 to 8/27 1946 and that I last saw him alive on 8/27 1946

Immediate cause of death Carcinomatosis

Due to Ca of Prostate

Due to C Metastasis

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE B. D. Wadsworth M.D.

Address Wadsworth md Date signed 9/16/46

RECEIVED  
SEP 10 1946  
HEAD &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

## CERTIFICATE OF DEATH

Reg. Dist. No. 102

## 1. PLACE OF DEATH:

County..... Charles  
 City or town..... Dorchester, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 72 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md County..... Charles  
 City or town..... Dorchester  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Rachel Mandue (Mandue)

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Wilmer Mandue

7. Birth date of deceased (mo., day, yr.)

Not known

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

Approx 72

..... hrs. .... min.

9. Birthplace

Dorchester, Md  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

FATHER

12. Name

Not known

13. Birthplace

MOTHER

14. Maiden name

Sarah Simpson

15. Birthplace

Charles Co. Md.

16. Informant

Mary Simpson

Address

Dorchester, Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept. 12, 1946  
(month) (day) (year)

Cemetery or crematory

Mt Hope

Location

Tronsides, Md.

18. Funeral director

Penny A Cofer

Address

Olson Springs, Md.

19.

Sept 13, 1946  
(Date rec'd by registrar)

19

J N Thompson  
Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 10<sup>th</sup> 1946 at 420 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 6 1946 to Sept 10 1946  
and that I last saw him alive on Sept. 19 1946

Immediate cause of death

Chronic Myocarditis

DURATION

1 yr.

Due to

Due to

Other conditions

Cirrhosis liver1 month

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

23. SIGNATURE

Dr. Susan M. S.

M. D. or other

Address Indian Head, Md. Date signed 9-10-46

RECEIVED  
SEP 14 1946  
BUREAU OF  
AERONAUTICS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-8

## CERTIFICATE OF DEATH

Reg. Dist. No. 18968 105

## 1. PLACE OF DEATH:

County..... Charles  
 City or town..... Honover  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Charles  
 City or town..... Honover  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Samuel F. Skinner

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Rosa E. Skinner

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age 70 years

8. AGE: Years 70 Months 2 Days 18 If less than one day  
 hrs. min.

9. Birthplace Honover, Chas. Co., Md.  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business State Roads12. Name William Skinner13. Birthplace Charles Co., Md.14. Maiden name Gracie Shannon15. Birthplace Charles Co., Md.16. Informant Harry L. SkinnerAddress Oxon Hill, Md.17. Burial (Burial, cremation, or removal, where?) Date thereof Sept 17 46  
(month) (day) (year)Cemetery or crematory BaptistLocation Nahant18. Funeral director Smith & RyanAddress Waldorf, Md.19. Sept 17 46 Registrar M. B. Howell  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1946 at 6:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 1946 to Sept 1946  
 and that I last saw him alive on Sept 1946

Immediate cause of death

Carcinoma of liver & stomach

Due to

Due to poison

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE George C. Bicknell M.D.  
M. D. or otherAddress Washington, Md. Date signed Sept 14 46

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF PUBLIC HEALTH  
WASHINGTON, D. C.

RECEIVED  
SEP 20 1946  
BUREAU V. B.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 946

## CERTIFICATE OF DEATH

★ 08969

Reg. Dist. No. 101

### 1. PLACE OF DEATH:

County Charles  
City or town Crossroads  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 50 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Charles  
City or town Crossroads  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.

### 3.(a) FULL NAME

John Richard Thomas

### 3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Emma L. Thomas

7. Birth date of deceased (mo., day, yr.) Nov. 10 1888 6.(c) If alive, give age 60 years

8. AGE: Years 62 Months 10 Days 9 If less than one day  
.....hrs. ....min.

9. Birthplace Baltimore Maryland  
(Town, county, and state)

10. Usual occupation Farmer

### 11. Industry or business

FATHER 12. Name John Richard Thomas  
13. Birthplace Baltimore Md

MOTHER 14. Maiden name Elizabeth Durham  
15. Birthplace Salisbury, Md

16. Informant Emma L. Thomas  
Address Crossroads, Md.

17. Burial Date thereof Sept. 21 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baptist  
Location Uniontown

18. Funeral director Dwight Rigdon  
Address Waldorf, Md.

19. Sept. 20 19 46 Mary S. Gutterland  
(Date rec'd by registrar) (year) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1946 at 6:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 46 to Sept 19 46  
and that I last saw him alive on Sept. 18 1946

Immediate cause of death

Coronary Disease (Cardiac)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Geo. C. Bicknell, M.D.  
M. D. or other

Address Marbury Md Date signed Sept. 20 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 25 1946

BUREAU V.S.